MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

---

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Described in Attachment 4.19-A

TN No. 88-12 DATE/RECEIPT 9/21/88
SUPERSEDES DATE/APPROVED 6/9/89
TN No. NEW DATE/EFFECTIVE 7/1/88

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.a Outpatient hospital services.

All hospitals except the state owned and operated by the Department of Health and Human Services and all primary affiliated teaching hospitals for the University of North Carolina Medical Schools will be reimbursed 80% of their allowable cost. All state operated and owned facilities will be reimbursed their allowable costs in accordance with the provisions of the Medicare Provider Reimbursement Manual.

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.a.1. Supplemental Payments for Outpatient Hospital Services

Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50 percent of their Medicaid inpatient discharges for the 12-month period ending September 30, 1999 shall be entitled to an additional payment for outpatient hospital services in an amount determined by the Director of the Division of Medical Assistance, subject to the following provisions:

(1) To ensure that the payments authorized by this Paragraph for qualified public hospitals that qualify under the criteria in Subparagraph A., below do not exceed the upper limits established by 42 CFR 447.321, the maximum payments authorized for qualified public hospitals shall be determined for all such qualified public hospitals for the 12-month period ending September 30, 1999 by calculating the "Outpatient Medicaid Deficit" for each hospital. The Outpatient Medicaid Deficit shall be calculated by ascertaining the reasonable cost of outpatient hospital Medicaid services; plus the reasonable direct and indirect costs attributable to outpatient Medicaid services of operating Medicare approved graduate medical education programs; less Medicaid payments received or to be received for these services. For purposes of this Subparagraph:

A. A qualified public hospital is a hospital that meets the other requirements of this Paragraph and:

(i) was owned or operated by a State (or by an instrumentality or a unit of government within a State) from September 16, 1999 through and including September 30, 1999; and

(ii) verified its status as a public hospital by certifying State, local, hospital district or authority government control on the most recent version of Form HCFA-1514 filed with the Health Care Financing Administration, U.S. Department of Health and Human Services on or before September 16, 1999; and

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(iii) files with the Division on or before September 16, 1999 by use of a form prescribed by the Division, a certificate of public expenditures to support a portion of the non-federal share of the payment it will receive pursuant to this Paragraph.

B. Reasonable costs shall be ascertained in accordance with the provisions of the Medicare Provider Reimbursement Manual as defined on page 9 Paragraph (b) of 4.19-A.

C. The phrase "Medicaid payments received or to be received for these services" shall exclude all Medicaid disproportionate share hospital payments received or to be received.

(2) Qualified public hospitals shall receive a payment under this Paragraph in an amount (including the public expenditures certified to the Division by each hospital for a portion of the non-federal share) not to exceed each hospital's Outpatient Medicaid Deficit.

(3) Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50% of their Medicaid inpatient discharges for the 12-months ending September 30, 1999 that are not qualified public hospitals as defined in this Paragraph shall be entitled to an additional payment under this Paragraph for their Outpatient Medicaid Deficit calculated in accordance with Subparagraph (1) in an amount not to exceed 67.43 percent of their Outpatient Medicaid Deficit.

(4) Payments authorized by this Paragraph shall be made solely on the basis of an estimate of costs incurred and payments received for Medicaid outpatient services during the twelve months ending September 30, 1999. The Director of the Division of Medical Assistance shall determine the amount of the estimated payments received for Medicaid services as reported on cost reports for the fiscal year ending in 1998 filed before September 16, 1999 and supplemented by additional financial information available to the Director when the estimated payments are calculated if and to the extent that the Director concludes that the additional financial information is reliable and relevant.

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(5) To ensure that estimated payments pursuant to this Paragraph do not exceed the state aggregate upper limits to such payments established by applicable federal law and regulation (42 CFR 447.321), such payments shall be cost settled within twelve months of receipt of the completed cost report covering the 12 month period ending September 30, 1999. Hospitals that receive payments in excess of unreimbursed reasonable costs as defined in this Paragraph shall promptly refund their proportionate share of any payments that exceed the state aggregate upper limits as specified by 42 CFR 447.321. No additional payment shall be made in connection with the cost settlement.

(6) The payments authorized by this Paragraph shall be effective in accordance with G.S. 108A-55(c).

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

(1) Provider clinics are paid on the basis of the principles and at the Medicare determined rates specified in the Medicare regulation in Part 405, Subpart D not to exceed the Medicare established limits.

(2) Independent clinics are paid for all services offered by the clinic at a single cost-reimbursement rate for clinic visit, established by the Medicare carrier, that includes the cost of all services furnished by the clinic.

(3) Effective October 1, 1993, physician-provided services at a hospital inpatient or outpatient location are paid at the existing fee-for-service rate for those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the rural health clinic location.

2.c. Services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred percent (100%) of reasonable cost, not to exceed the Medicare established limits, as determined in an annual cost report, based on Medicare principles and methods when:

(1) It is receiving a grant under Section 329 (migrant health centers), 330 (community health centers) or 340 (health care centers for the homeless), Public Housing Health Centers receiving grant funds under Section 340A of the Public Health Service Act and Urban Indian organizations receiving funds under Title V of the Indian Health Improvement Act are FQHC's effective calendar quarter beginning or after October 1, 1993;

(2) It meets the requirements for receiving a Public Health Service grant or was treated as a comprehensive federally funded health center as of January 1, 1990.

(3) Nutrition services are provided by rural health centers and FQHC. Provider are reimbursed in accordance with reimbursement methodologies established for services provided by rural health clinics and FQHC's as based on Medicare principles.

(4) Effective October 1, 1993, physician-provided services at a hospital inpatient a outpatient location are paid at the existing fee-for-service rate for those clinics whose agreement with their physician states that the clinic doesn't compensate the physician for services in a location other than at the federally qualified health clinic location.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

3. Other Laboratory and X-ray Services

Fees for independent laboratory services shall be the lower of the submitted charge or the appropriate fee from the fee schedules in effect on July 1, 1990.

a. Annual fees are increased each January 1, based on the forecast of the Gross National Product (GNP) implicit price deflator, but not to exceed the percentage increase granted by the N.C. State Legislature and not to exceed the Medicare maximum fees.

b. Fees for new services are established based on fees for similar existing services. If there are no similar services the fee is set at the Medicare maximum fee. If there is no Medicare fee available, the fee is established at 60 percent of charges until a Medicare fee is established.

The above methodology shall also apply to laboratory services paid to hospital outpatient facilities, physicians, and any provider supplying outpatient laboratory services.

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

4.a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Described in 4.19-D

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

For providers other than individual practitioners a negotiated encounter rate is not to exceed reasonable cost. This rate shall also serve as the upper limit for reimbursement for individual practitioners providing the same services.

Services contained in 1905(a) and not listed as covered services in the state agency manuals/state plan will be provided. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will be at statewide usual and customary fees. If the provider is a government agency and/or a non-profit organization, the reimbursement will be no greater than actual costs. This is in compliance with 45 CFR Subpart Q.

Additional service categories are reimbursed as follows:

Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B, Section 13, page 1.

Clinic services are reimbursed in accordance with Attachment 4.19-B, Section 9, page 1.

Hospital Outpatient services are reimbursed in accordance with Attachment 4.19-B, Section 2, page 1.

Nutrition services will be reimbursed in accordance with reimbursement methodologies as based on negotiated fee not to exceed reasonable cost.

Hearing aids and hearing aid accessories are reimbursed at invoice cost (invoices must accompany claims for aids and accessories). Fitting and dispensing services are reimbursed at a fixed reasonable reimbursement fee.

Batteries are reimbursed at current retail costs; an invoice is not required and a dispensing fee is not allowed.

Payment is based on negotiated fee not to exceed reasonable cost.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Home Health Agencies are reimbursed in accordance with Attachment 4.19-B, Section 7, pages 1-5.

Physician services are reimbursed in accordance with Attachment 4.19-B, Section 5, pages 1-21.

The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies.